# MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

# COMPANION GUIDE FOR THE HIPAA 837 PROFESSIONAL CLAIM ADDENDA VERSION 4010A1

**July 1, 2003**

**Effective for Claims Submitted On or After June 16, 2002**

Michigan Department of Community Health

MDCH

MSA MEDICAL SERVICES ADMINISTRATION

This document is intended as a companion to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional Claim Addenda, ASC X12N 837 (004010X098A1)**, dated October 2002, and the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional Claim, ASC X12N 837 (004010X098)**, dated May 2000. This document should be used in conjunction with all MDCH claim submission and claim processing guidelines. This document follows guidelines authorized by the Department of Health and Human Services on September 17, 2001. The clarifications described herein include:

- identifiers to use when a national standard has not been adopted [and]
- parameters in the implementation guide that provide options

(The Addenda implementation guide can be found at http://www.wpc-edi.com/hipaa/hipaa_40.asp. HHS guidance on data clarifications can be found at http://aspe.os.dhhs.gov/admnsimp/q0321.htm)

NOTE: ***Page references*** from the Implementation Guides refer to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional Claim, ASC X12N 837 (004010X098)** ("Version 4010"), unless otherwise noted (with an asterisk(*)) as referring to the Addenda Implementation Guides ("Version 4010A1"), **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional Claim Addenda, ASC X12N 837 (004010X098A1)**.

| Page* | Loop | Segment | Data Element | Comments |
|---|---|---|---|---|
| 62 | | ST – Transaction Set Header | | MDCH accepts a maximum of 5,000 CLM segments in a single transaction (ST-SE) as recommended by the HIPAA-mandated implementation guide. |
| 65 | | BHT – (Header) Beginning of Hierarchical Transaction | BHT06 – Transaction Type Code | Use “CH” (Chargeable). |
| 11* | | REF – (Header) Transmission Type Identification | REF02 – Transmission Type Code | Use “004010X098A1” if using the October 2002 Addenda Implementation Guide. |
| 69 | 1000A – Submitter Name | NM1 – Submitter Name | NM109 – Submitter Identifier | Use the 4-character billing agent ID assigned by MDCH. This value should match GS02 (Application Sender’s Code). |
| 75 | 1000B – Receiver Name | NM1 – Receiver Name | NM109 – Receiver Primary Identifier | Use “D00111” for MDCH. |
| 78 | 2000A – Billing/Pay-to Provider Hierarchical Level | HL – Hierarchical Level | HL01 – Hierarchical ID Number | HL01 must begin with “1” and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01. |
| 86 | 2010AA – Billing Provider Name | NM1 – Billing Provider Name | NM108 – Identification Code Qualifier | Use “24” (EIN) or “34” (SSN). |
| 86 | 2010AA – Billing Provider Name | NM1 – Billing Provider Name | NM109 – Billing Provider Identifier | Use the EIN or SSN value assigned to the MDCH provider ID identified in Loop 2010AA REF02 (Billing Provider Additional Identifier). |
| 92 | 2010AA – Billing Provider Name | REF – Billing Provider Secondary Identification | REF01 – Reference Identification Qualifier | Use “1D” (Medicaid Provider Number). |
| 92 | 2010AA – Billing Provider Name | REF – Billing Provider Secondary Identification | REF02 – Billing Provider Secondary Identification Number | Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID). |
| 110 | 2000B – Subscriber Hierarchical Level | SBR – Subscriber Information | SBR01 – Payer Responsibility Sequence Number Code | Use “P” if MDCH is the only payer (that is, patient has no Medicare or other insurance), “S” if there is one other payer, or “T” if there are two or more other payers. |

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| Page* | Loop | Segment | Data Element | Comments |
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| 112 | 2000B – Subscriber Hierarchical Level | SBR – Subscriber Information | SBR09 – Claim Filing Indicator Code | Use “MC” for Michigan Medicaid, “TV” for CSHCS (Title V), or “11” for State Medical Plan (Other Non-Federal). If beneficiary qualifies for more than one program, or other MDCH program not listed, use “MC”. |
| 119 | 2010BA – Subscriber Name | NM1 – Subscriber Name | NM108 – Identification Code Qualifier | Use “MI” (Member Identification Number). |
| 119 | 2010BA – Subscriber Name | NM1 – Subscriber Name | NM109 – Subscriber Primary Identifier | Use the patient’s 8-digit beneficiary ID number assigned by MDCH. |
| 131 | 2010BB – Payer Name | NM1 – Payer Name | NM108 – Identification Code Qualifier | Use “PI” (Payor Identification). |
| 131 | 2010BB – Payer Name | NM1 – Payer Name | NM109 – Payer Identifier | Use “D00111” for MDCH. |
| 152 | 2000C – Patient Hierarchical Level | | | MDCH business rules require that the patient is always the subscriber. Therefore, MDCH does not expect providers to submit any Loop 2000C (Patient Hierarchical Levels) in a transaction set.<br>Transaction sets that contain Loop 2000C (Patient Hierarchical Level) information will be rejected. |
| 170 | 2300 – Claim Information | | | Note that the HIPAA-mandated implementation guide allows a maximum of 100 repetitions of the 2300 claim information within each Loop 2000B (Subscriber Hierarchical Level).<br>Transaction sets that do not associate Loop 2300 Claim Information with Loop 2000B (Subscriber Hierarchical Levels) will be rejected. |
| 173 | 2300 – Claim Information | CLM – Claim Information | CLM05-1 – Facility Code Value | Place of service codes as defined by the Center for Medicare and Medicaid Services (formerly HCFA). See cms.hhs.gov/state/poshome.asp |
| 173 | 2300 – Claim Information | CLM – Claim Information | CLM05-3 – Claim Frequency Type Code | Use “1” on original claim submissions; use “7” for claim replacement, and use “8” for claim void/cancel. For both “7” and “8”, include the original CRN, as indicated in Loop 2300 REF (Original Reference Number (ICN/DCN)). |

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| 212 | 2300 – Claim Information | DTP – Date – Assumed and Relinquished Care Dates | | MDCH requires this on claims to indicate "assumed care date" and "relinquished care date" for situations where providers share post-operative care. When a surgeon submits the claim, "091" is used in DTP01 to show the date care was relinquished to another physician. When the second physician submits that claim, "090" is used to indicate the date care was assumed for the patient. |
| 228 | 2300 – Claim Information | REF – Prior Authorization or Referral Number | REF01 – Reference Identification Qualifier | When submitting a Prior Authorization number, use "G1". |
| 228 | 2300 – Claim Information | REF – Prior Authorization or Referral Number | REF02 – Prior Authorization or Referral Number | Use the 9-digit Prior Authorization number assigned by MDCH. |
| 230 | 2300 – Claim Information | REF – Original Reference Number (ICN/DCN) | REF01 – Reference Identification Qualifier | When submitting a claim replacement or claim void/cancel (as indicated by Loop 2300 CLM05-3 (Claim Frequency Type Code)), use "F8". |
| 230 | 2300 – Claim Information | REF – Original Reference Number (ICN/DCN) | REF02 – Claim Original Reference Number | Use the 10-digit CRN assigned by MDCH to the last approved claim. |
| 247 | 2300 – Claim Information | NTE – Claim Note | NTE01 – Note Reference Code | Use "ADD". |
| 247 | 2300 – Claim Information | NTE – Claim Note | NTE02 – Claim Note Text | Provide free-text remarks, if needed |
| 265 | 2300 – Claim Information | HI – Health Care Diagnosis Code | HI01-1 – Diagnosis Type Code | MDCH requires this element on every claim. Do not use a decimal point. |
| 288 | 2310A – Referring Provider Name | REF – Referring Provider Secondary Identification | REF01 – Reference Identification Qualifier | Use "1D" (Medicaid Provider Number). |
| 289 | 2310A – Referring Provider Name | REF – Referring Provider Secondary Identification | REF02 – Referring Provider Secondary Identifier | Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID). |

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| 290 | 2310B – Rendering Provider Name | | | This loop will normally not be used since MDCH expects the billing provider to be the rendering provider (Loop 2000A – Billing/Pay-to Provider Hierarchical Level). In the case where a substitute (locum tenens) was used, that person should be entered here. |
| 292 | 2310B – Rendering Provider Name | NM1 – Rendering Provider Name | NM108 – Identification Code Qualifier | Use “24” (EIN) or “34” (SSN). |
| 292 | 2310B – Rendering Provider Name | NM1 – Rendering Provider Name | NM109 – Rendering Provider Identifier | Use the EIN or SSN value assigned to the MDCH provider ID identified in Loop 2310B REF02 (Rendering Provider Secondary Identifier). |
| 296 | 2310B – Rendering Provider Name | REF – Rendering Provider Secondary Identification | REF01 – Reference Identification Qualifier | Use “1D” (Medicaid Provider Number). |
| 297 | 2310B – Rendering Provider Name | REF – Rendering Provider Secondary Identification | REF02 – Rendering Provider Secondary Identifier | Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID). |
| 318 | 2320 – Other Subscriber Information | SBR – Other Subscriber Information | | If the patient has other insurance (Medicare, for example), repeat this loop for each other payer. Do not put information about MDCH coverage in this loop. |
| 319 | 2320 – Other Subscriber Information | SBR – Other Subscriber Information | SBR01 – Payer Responsibility Sequence Number Code | If the patient has other insurance, report primary payer coverage with code “P” and any other insurance with codes “S” or “T”, as appropriate. |
| 319 | 2320 – Other Subscriber Information | SBR – Other Subscriber Information | SBR02 – Individual Relationship Code | The code carried in this element is the patient’s relationship to the person who is insured. For example, if a child with Medicaid also has coverage under the father’s insurance, use code “19” (Child). |
| 320 | 2320 – Other Subscriber Information | SBR – Other Subscriber Information | SBR03 – Insured Group or Policy Number | Use the subscriber’s group number (assigned by the other payer), not the number that uniquely identifies the subscriber. For example, group numbers assigned by BCBSM are usually 5 digits. |
| 321 | 2320 – Other Subscriber Information | SBR – Other Subscriber Information | SBR05 – Insurance Type Code | Do not use “MC” (Medicaid) in this element. |
| 321 | 2320 – Other Subscriber Information | SBR – Other Subscriber Information | SBR09 – Claim Filing Indicator Code | Do not use “MC” (Medicaid) or “TV” (Title V) in this element. |

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| 351 | 2330A – Other Subscriber Name | NM1 – Other Subscriber Name | NM103, NM104, NM105, NM107 – Other Insured Last Name, First Name, Middle Name, Suffix | Use the name of the subscriber as it appears on the files of the other payer. |
| 352 | 2330A – Other Subscriber Name | NM1 – Other Subscriber Name | NM108 – Identification Code Qualifier | Use “MI” (Member Identification Number). |
| 352 | 2330A – Other Subscriber Name | NM1 – Other Subscriber Name | NM109 – Other Insured Identifier | Use the unique member number assigned to the subscriber by the other payer indicated in Loop 2330B (Other Payer Name). For example, member numbers assigned by BCBSM are usually 3 letters followed by 9 digits. |
| 357 | 2330A – Other Subscriber Name | REF – Other Subscriber Secondary Identification | REF01 – Reference Identification Qualifier | Do not use “1W” (Member Identification Number). |
| 360 | 2330B – Other Payer Name | NM1 – Other Payer Name | NM108 – Identification Code Qualifier | Use “PI” (Payor Identification). |
| 361 | 2330B – Other Payer Name | NM1 – Other Payer Name | NM109 – Other Payer Primary Identifier | Use the carrier code assigned by MDCH (see MDCH website for a listing of carrier codes). Example values for this field: BCBSM Traditional would be “00029005”; Medicare Part A (United Government Services) would be “00452”; and, Medicare Part B (Wisconsin Physician Services) would be “00953.” |
| 380 | 2330D – Other Payer Referring Provider | REF – Other Payer Referring Provider Identification | REF01 – Reference Identification Qualifier | Do not use “1D” (Medicaid Provider Number). |
| 384 | 2330E – Other Payer Rendering Provider | REF – Other Payer Rendering Provider Secondary Identification | REF01 – Reference Identification Qualifier | Do not use “1D” (Medicaid Provider Number). |
| 388 | 2330F – Other Payer Purchased Service Provider | REF – Other Payer Purchased Service Provider Identification | REF01 – Reference Identification Qualifier | Do not use “1D” (Medicaid Provider Number). |

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| Page* | Loop | Segment | Data Element | Comments |
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| 392 | 2330G – Other Payer Service Facility Location | REF – Other Payer Service Facility Location Identification | REF01 – Reference Identification Qualifier | Do not use “1D” (Medicaid Provider Number). |
| 396 | 2330H – Other Payer Supervising Provider | REF – Other Payer Supervising Provider Identification | REF01 – Reference Identification Qualifier | Do not use “1D” (Medicaid Provider Number). |
| 56* | 2400 – Service Line | SV1 – Professional Service | SV101-1 – Product/Service ID Qualifier | Use “HC” Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes. |
| 56* | 2400 – Service Line | SV1 – Professional Service | SV101-2 – Procedure Code | MDCH expects the Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes to be included for each service line. |
| 73* | 2410 – Drug Identification | LIN – Drug Identification | LIN03 – National Drug Code | This element is used for billing/reporting of prescribed drugs that may be part of the service(s) described in Loop 2400 SV1 (Professional Service).<br>MDCH will only process the first repeat of Loop 2410 LIN. Any additional repeats may be ignored. |
| 554 | 2430 – Line Adjudication Information | | | MDCH expects this loop for each payer identified in Loop 2320 (Other Subscriber Information), except when that payer has adjudicated this claim at the claim level only. |
| 554 | 2430 – Line Adjudication Information | | | MDCH expects this loop to be populated for each payer identified in Loop 2320 (Other Subscriber Information). |

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